Reliability of Diagnoses

USE OF STRUCTURED INTERVIEWS BY PSYCHIATRISTS IN REAL CLINICAL SETTINGS:
Results of an Open-question Survey

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ABSTRACT

Psychiatry (Edgemont) readers were surveyed about whether or not they use structured interviews in real clinical settings. Forty psychiatrists responded to the survey: six psychiatrists in private practices and 34 faculty psychiatrists. The majority of psychiatrists (72.5%) do not use structured interviews and 27.5 percent use some structured interviews in clinical settings. The three most commonly cited reasons for not using structured interviews were "constraints of time," "structured interviews are research tools," and "structured interviews interfere with establishing rapport with patients." Other reasons why psychiatrists do not use structured interviews are analyzed and discussed.

KEY WORDS

structured interview, clinical setting, psychiatry, reliability of diagnosis

BACKGROUND

In an article published in the July issue of *Psychiatry* (Edgemont),[1] I opined that psychiatrists do not use structured interviews in real clinical settings for the following three reasons: 1) structured interviews are designed as research tools to be used in research settings and are not designed for psychiatrists to use in real clinical settings; 2) structured interviews are time-consuming; and 3) the rules of structured interviews make it difficult for the psychiatrist to establish rapport with the patient.

To obtain input from practicing psychiatrists, I invited the readers of *Psychiatry* (Edgemont) to answer the the following questions:

1. Do you use structured interviews (not just a rating scale) in your routine clinical practice, whether inpatient or outpatient?
2. If your answer is no, why not?
3. If your answer is yes, which structured interview do you use? For what percentage of your patients' load do you use the structured interview routinely?

The purpose of this article is to summarize psychiatrists' responses to the survey about whether or not they routinely use structured interviews. In addition, reasons cited for not using structured interviews are analyzed and discussed.

RESULTS

Forty psychiatrists responded to the open survey: six psychiatrists in private practice and 34 psychiatrists in faculty positions. Twenty-nine psychiatrists (72.5%) said that they

do not use structured interviews in clinical settings; eleven psychiatrists (27.5%) said they use structured interviews in clinical settings; seven psychiatrists (17.5%) said they use structured interviews with all patients; and four psychiatrists (10%) said they use them occasionally with a subset of patients only. Among the six psychiatrists in private practice who use structured interviews, one uses an unpublished tool that he developed and has used in his private practice for 20 years. The study results show that faculty psychiatrists, assumedly by virtue of their academic positions, were more likely to use structured interviews in clinical settings.

Table 1 shows the users and nonusers of structured interviews and the names of the instruments used. Among the users of the structured interviews, the Mini-International Neuropsychiatric Interview (M.I.N.I.) is the most commonly used structured interview by psychiatrists in clinical settings.[2] Three psychiatrists responded that they use the M.I.N.I. with all patients (7.5%), and one psychiatrist uses the M.I.N.I. only with some difficult patients (2.5%). The clinical derivatives of the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) are used by two psychiatrists (5%).[3,4] The Affective Disorders Evaluation (ADE)[5,6] is used by two psychiatrists (5%); one psychiatrist uses the ADE with all patients and the other uses the ADE with some patients only. One child psychiatrist uses the Autism Diagnostic Observation Schedule (ADOS)[7] in patients with autism (2.5%). Two psychiatrists use unpublished instruments.

The majority of psychiatrists (72.5%) responded that they do not use structured interviews in clinical settings. The reasons cited were grouped into the following:

TABLE 1. Users and nonusers of structured interviews (SI): responses from 40 psychiatrists

RESPONDENT TYPE		NUMBER (N=40)	PERCENTAGE
Nonusers of SI		29	72.5
Users of SI		11	27.5
Complete use of SI		7	17.5
Partial use of SI		4	10
NAME OF INSTRUMENT	**LEVEL OF USE**	**NUMBER (N=40)**	**PERCENTAGE**
M.I.N.I.	Complete use	3	7.5
SCAN Clinical Version	Complete use	2	5
ADE	Complete use	1	2.5
Mental Health Form (unpublished)	Complete use	1	2.5
M.I.N.I.	Partial use	1	2.5
ADE	Partial use	1	2.5
ADOS	Partial use	1	2.5
Sexual Events Form (unpublished)	Partial use	1	2.5

A. Structured interviews are time consuming.
B. Structured interviews are designed for research and not designed for clinical use by psychiatrists. Structured interviews were described as "cumbersome," "unwieldy," "inconvenient," "inflexible," "user unfriendly," and "complicated."
C. Structured interviews interfere with establishing rapport with patients.
D. Psychiatrists do not need to use structured interviews. The following reasons were given:
   1. Clinical skills acquired through years of training are sufficient to diagnose mental disorders and superseded any structured interview.
   2. Clinical interviews can reveal all the information needed to diagnose and manage patients.
   3. Structured interviews are based on well-known criteria.

TABLE 2. Respondents' reasons for using or not using structured interviews (SI)

Respondent Number	Use SI	Reason A	Reason B	Reason C	Reason D	Reason E	Reason F	Reasons G–K
1	No		X					
2	No	X		X	X			
3	No	X	X	X				
4	No		X	X				
5	No	X	X	X		X		I
6	Yes	X						
7	No		X	X	X			
8	N o	X		X		X		G
9	Yes	X	X		X			
10	Yes							
11	No							
12	No	X						
13	No				X			K
14	No	X						
15	Yes							
16	No	X	X		X			
17	No	X					X	
18	No	X	X	X				
19	No	X	X	X				
20	Yes							
21	No	X	X	X	X			
22	No			X				
23	No			X				
24	No	X	X		X			
25	No	X						
26	No		X		X			
27	No	X	X	X				
28	No	X					X	
29	Yes							
30	Yes							
31	No							J
32	Yes							
33	Yes							
34	Yes							
35	No							H
36	No							
3 7	No	X						
38	No							
39	Yes				X			
40	No	X			X			

4. All vital information about the patient is gathered over time.
5. Structured interviews reveal little about the patient's disposition, behaviors, experiences, and ever-changing personal circumstances that dictate his or her treatment requirements at any given point in time.
6. Understanding the patient is more important than a diagnosis.

E. Structured interviews are based on a flawed classification system.
F. The use of structured interviews yields no financial benefits.
G. Structured interviews do not account for differences among patients (e.g. cultural differences).
H. Structured interviews do not account for patients with disabilities (e.g., patients with mental retardation).
I. Structured interviews restrict the creativity of the interviewer.
J. Structured interviews force psychiatrists to act like programmed computers.
K. Psychiatrists are not trained to use structured interviews.

Table 2 shows the individual responses of the 40 psychiatrists who use and do not use structured interviews and the reasons they cited for not using them. Table 3 summarizes the reasons for not using structured interviews. The most commonly cited reason why psychiatrists do not use structured interviews was, "Structured interviews are time consuming" (19 citations, 30.1% of all citations). "Structured interviews are designed for research and not designed for clinical use," was the second most commonly cited reason (13 citations, 20.6% of all citations). "Structured interviews interfere with establishing rapport with patients," was cited 12 times (19.0%). "Psychiatrists do not need to use structured interviews,"

TABLE 3. Reasons why psychiatrists do not use structured interviews in real clinical settings (63 citations from 40 psychiatrists)

REASON	NUMBER OF TIMES CITED AS A REASON	PERCENTAGE FROM 63 CITATIONS
A	19	30.1
B	13	20.6
C	12	19
D	10	15.9
E	2	3.2
F	2	3.2
G	1	1.6
H	1	1.6
I	1	1.6
J	1	1.6
K	1	1.6

was cited 10 times (15.9%). "Structured interviews are based on a flawed classification system." was cited twice (3.2%). "No financial reimbursement for using structured interviews," was also cited twice (3.2%). Each of the other reasons (G, H, I, J, K) was cited one time.

DISCUSSION

This open-question survey study has limitations. The number of respondents is small (40 respondents), and the procedures used to solicit the responses from psychiatrists were arbitrary.

Readers of *Psychiatry* (Edgemont) were solicited to respond through a published invitation in the journal. An e-mailed version of the survey was also sent to the editorial advisory board members of the journal as well as colleagues of the author.

Despite the small number of respondents, the results of the survey can be informative, since there is currently little research on the subject.

I previously hypothesized that three main reasons prevent psychiatrists from using structured interviews in real clinical settings: structured interviews are designed as research tools, they are time-consuming, and they interfere with establishing rapport with the patients.[1] The results of this survey appear to confirm the hypothesis as these three reasons combined accounted for 69.7 percent of the cited reasons why psychiatrist do not use structured interviews in clinical settings. The respondents also identified eight additional reasons for not using structured interviews, and these accounted for 30.3 percent of the cited reasons. An interesting finding is that 15.9 percent of the respondents said that psychiatrists do not need to use any structured interviews to diagnose or manage patients.

In my opinion, psychiatrists do appreciate the proven value of the measurement embedded in structured interviews. However, psychiatrists cannot change their methods of assessment to overcome the inadequacies of the existing structured interviews. Psychiatrists develop their clinical skills over years of training and experience. A seasoned psychiatrist can spend 30 minutes interviewing a new patient, establish a good rapport with the patient, and at the end of the interview, he or she can have a valid provisional diagnosis and initial treatment plan. Most, if not all, psychiatrists will resist utilizing any tool that mechanizes the interview process, prevents them from following the leads created by the patient's responses, and jeopardizes development of rapport with patients. This major nonuse of structured interviews by psychiatrists can be overcome by developing new clinical tools that accommodate and complement what psychiatrists do in clinical practice. These clinical tools should be efficient, should be designed for clinical use (e.g., measuring significant symptoms of clinical significance), and should not interfere with establishing rapport with patients. It is important to differentiate between patient self-reports and clinical assessment by psychiatrists. Positive symptoms reported by the patients do not necessarily require treatment. On the other hand, psychiatrists should evaluate symptoms of clinical significance that cause distress or impairment of function of the patient.

Finally, it is difficult to conclude from the survey whether or not psychiatrists want to use a tool, such as a structured interview, to aid in patient assessment. Ten psychiatrists (25%) said that they do not need any tool to interview patients, and eleven psychiatrists (27.5 %) use some type of existing structured tool. There is a new and external factor that may play a crucial role in whether or not psychiatirsts use structured interviews, which is the

trend toward computerizing all medical records. This factor may act as the catalyst that will force psychiatrists to use or adapt to using some of the existing tools or newly developed tools for psychiatric assessment in clinical settings.

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